

handed individual to insert needles into the left than into the right breast.

This number is surpassed in the case reported in the *Iowa Medical Journal* :—

A girl, aged 19, had the misfortune accidentally to run two needles in her left arm. These were extracted. The impression made upon her was such that during the next few weeks more than forty needles were extracted from the left arm and five from the left breast. The habit continued, so that in the end 132 needles were removed from her body, including thirty-five from the left breast and thirteen from the right breast.

A needle is not a very deadly instrument and few accidents have been recorded from their insertion in this manner but the following case reported by Untiedt is of interest :—

A hysterical girl, aged 19, thrust a needle into her left breast. Soon after this a pulsating tumour formed under the breast and the patient died. At the post-mortem examination an abscess containing about a pint of brown pus was found, in which lay a sewing needle one and a half inches long. The abscess communicated with the pericardium.

This is the only case of such a nature that I know recorded.

PRACTICAL HINTS IN MEDICINE (PSYCHOLOGICAL).

By R. TRAVERS SMITH,

M.D., F.R.C.P.I.,

*Consulting Physician to the West Middlesex Hospital ;
Physician to the Miller General Hospital.*

(*A Fellowship of Medicine Post-Graduate Lecture.*)

IN an address delivered last month, Sir Farquhar Buzzard stated: "There can be little doubt that more than half the ills to which man is prone originate in disturbances of the mind. There can be no doubt that they are more difficult to recognize, to

classify, and to treat than those of purely bodily origin, and that the dangers attached to unskilled practice in that department of medicine are at least equal to those associated with ignorant interference in any other." With this authoritative pronouncement, my experiences as a physician accord fully. Therefore, as on the last occasion on which I had the honour to address this audience, I dealt with some emergencies of organic neurology, it may prove useful to some of you to deal to-day with that mighty subject, "the powers of mind over matter," or the effects of the mind upon bodily functioning, and to be as practical and helpful as an hour will permit. I shall avoid touching upon the vast domain of conventional insanity, or upon the physiological disturbances, such as of the vegetative nervous and endocrine systems, which intervene between the mind and the ultimate symptoms it can manifest in bodily guise. So I shall deal with what are more appropriately called psycho-neuroses than neuroses, in that the former term emphasizes the lead of the mental element. My scheme is to categorize (rather than classify) some patients that we all meet, to give what can be nothing more exhaustive than a list of psychoneurotic manifestations arranged according to the functional systems they affect, and to intersperse some practical generalizations. Most of my remarks and examples will relate to the psychoneurosis called hysteria, or more usually, anxiety-hysteria.

CATEGORIES.

(1) Some illness or trauma occurring, the subjective symptoms of which persist long after recovery, as judged by physical signs. Frequently it is one symptom that dominates persistently. Common examples are aphonia after laryngitis; prostration after influenza; pain after appendicectomy; headache, or pain and stiffness of the back, after an injury.

(2) Some physical abnormality (insignificant in itself in that the same condition

leaves the majority who have it unperturbed, though aware of it) producing serious subjective symptoms. Examples: one, or a few, harmless pimples on the skin resulting in widespread itching and irritation, and insomnia; crepitation noticed in a joint which then becomes painful, the pain extending to other joints though they never creak.

(3) Some emotion as fright, grief, disappointment, disgust, or anger, not merely producing their somatic manifestations for a normal and reasonable time, but one or more of such manifestations persisting. This is the more likely to occur and persist when the manifestations are consciously represented as organic disease. Examples: persistent tremor, tachycardia, weeping, vomiting.

(4) Phobias, which may be defined as intense and apparently unwarrantable emotionalism stimulated by a given circumstance, such as dread of open or closed spaces, heights, travelling. Nosophobia, dread of disease, will concern us most.

(5) Some idea in the mind of which the patient is aware, though usually reluctant to state it, which idea he may have constructed by his own mentation, or have accepted it as that of another whose authority he respects. The idea, within limits that are hard to define, brings about its realization, certainly in as far as sensations and disordered functioning (dysfunctioning) can. The patient will usually say that it was his symptoms gave him the idea, but in practice some such idea can be tracked back to a time of life preceding the symptoms, though, for the time being, forgotten. Examples: Idea that twins have only one brain between them, "I have felt very stupid all my life"—that from a successful business man; idea, as parents were first cousins the children must go insane—result, constant introspection of mind, depression, associability; the doctor called a Bell's palsy "facial paralysis"—within a week the leg and arm on the same side were functionally

paretic, the patient's only conception of "paralysis." Such are examples of the far-reaching possibilities of auto- or hetero-suggestion when the ideas fall upon susceptible mentalities. Patients that come under the above five categories usually betray apprehension or fear in relation with their bodily symptoms, and intense nervous concentration upon them.

(6) In this category are those with, may be, a pronounced functional disability, but far from having any apprehension concerning it, they remain careless or even cheerful to a degree incompatible with organic disease and a normal mind. Examples: a girl with functional paraplegia for five years spent in bed or bath chair who said: "I never was downhearted in my life, I cheer the whole family"; a lady, aged 40, with anorexia nervosa, who cheerfully watched her own progressing emaciation and the consternation of her mother; a stammerer who lost his lucrative employment on this account, and re-established himself complacently in his poor parental home; the lady who smilingly tells her doctor of the many occasions she had been at death's door, and "given up" by the most skilled.

(7) Obsessing thoughts, not permitting dismissal from the mind; compulsive actions, such as stepping between the cracks of stone pavement; doubting, indecision, and changing mind concerning matters momentous or otherwise. With some patients, unbidden thoughts, as when of suicide or homicide, are very distressing, and prone to engender a phobia of losing all mental control. Examples: A man who cannot shave without the thought of cutting his throat; a young mother who cannot take her baby to the top of a bus and remain free from a thought of throwing it over. Patients in this category (obsessional psychoneurosis), unlike those in the others, surmise correctly that their troubles are of mental origin, are therefore the more reluctant to complain of them for fear of being considered insane, and may consult one wilfully obtruding some physical

symptom, in the hope of a universal panacea.

Now to proceed with a list of psychoneurotic manifestations (mainly hysterical) as they variously affect the separate bodily systems; but with this paramountly important caution—organic disease, also, can be primarily responsible for most of them.

ALIMENTARY SYSTEM.

Mouth.—Loss of appetite complete (anorexia nervosa), partial, or selective. Salivation, or dry mouth. Thirst (hysterical diabetes insipidus). Nervous concentration on a coated tongue, mirrored on every available occasion. Buccal pain and hyperæsthesia, an idea of cancer frequently underlies them.

Pharynx and Œsophagus.—Feeling of lump in the throat (emotional), followed by ideas of growths and obstruction. Dysphagia of all degrees, from inability to swallow a pill to almost total obstruction, due to spasm lasting unrelentingly till the brink of starvation may be reached. Such spasms can be demonstrated radiologically.

Stomach.—Subjective sensations from a mere sense of fullness to severe pain. Aerophagy, belching, retching, vomiting. Objectively may be found rapid or slow emptying, hyper- or hypochlorhydria, hyper- or hypotonicity, hyperæsthesia. Is it any wonder that such cases tend to gravitate to the operating theatre? When they do, their last state becomes worse than their first, as a rule.

Appendix.—Beware of diagnosing appendicitis on subjective symptoms alone, no matter how closely they may imitate those of the genuine article. Doctors can unwittingly suggest symptoms of acute appendicitis by telling a patient that they must seek medical aid immediately, in order to avoid danger, on the appearance of any pain whatsoever in the lower abdomen. In my experience, when in doubt as to the future good behaviour of an appendix, better have it removed. To exemplify the far-reaching effect of suggestibility, a lady told me that

one of her many doctors had diagnosed a “growling” appendix, and that he was right, in that she had noticed herself very “snappy” ever since.

Colon.—Life-long constipation and reliance upon purgatives can be of psychic origin. Particularly when of such origin, it is generally accompanied by nervous concentration on the character of the stools, ideas of being systematically “poisoned,” and, objectively, there is liability to excessive mucous discharge, so-called “mucous colitis”; though evidence of inflammation be absent. With the conception that “mucous colitis” has a local colonic pathology, it has become a fashionable complaint. Diarrhoea, flatulence, and borborygmus can be of purely nervous origin. Spasm of the anal sphincter producing pencil stools is a common nervous phenomenon that doctors are predisposed to interpret as a sure sign of organic disease of the rectum, especially when they observe it in themselves. Pruritus ani is, in many cases, nervously engendered or aggravated.

Visceroptosis of Digestive Tract.—Into this debatable subject I shall not venture, further than to say that visceroptoses and psychoneuroses have a most intimate association, the latter being frequently the primary. In fact, a worthy physical sign of a psychoneurosis is some form of abdominal support, clung to, though it and its utility are well outworn. Nor, hardly, could there be more telling evidence of the psychotherapeutic powers of a physician, than a waiting-room hung with discarded abdominal belts, as is the Grotto at Lourdes with crutches.

URINARY SYSTEM.

Pain in the loins is more usually a conceptual symptom of kidney disease than otherwise. Many lumbar pains can be removed by reassurance as to the healthy condition of the kidneys. Every doctor must have observed the development of pain in a nervous subject who had been told, misguidedly, that a kidney was “floating.” A lady thus informed could feel her kidneys

floating up to her throat whenever she stood up, so kept in bed. Disturbances in micturition may scale from some delay and embarrassment in performing the act in a public urinal, or against time, to a retention that causes overflow incontinence. Intermittent cystic or urethral spasms may cause pain and irregular urinary flow. Diurnal frequency of micturition of nervous origin may result in a patient eschewing social gatherings or travel, or phobias of these may produce the frequency. Nocturnal enuresis is, in my experience, more generally attributable to psychoneurosis than to physical abnormality or to faulty urinary constituents; circumcision can intensify it. I once saw a small boy in a public school who had nearly succeeded in inducing gangrene of his penis by adjusting a strong steel clip to it nightly as a cure for bed-wetting—an example of mental factors that may be a cause of perpetuation. Objectively one may find excessive or diminished quantities of urine, alkalinity and phosphatic cloudiness, and, be it understood, that postural and transient albuminuria is far from rare, particularly in the neuroticism of adolescence.

RESPIRATORY SYSTEM.

Nasal catarrh, especially in the form of "paroxysmal rhinorrhœa." Laryngeal hawking or cough. Aphonia of any degree or persistence. Laryngeal spasms. Dyspnœa or tachypnœa. Diminished respiration with compensatory sighing. Excessive bronchial secretion can be kept going from an anxiety focus upon it just as can nasal secretion till the forgotten handkerchief is replaced. Chest pain is an urgent symptom amongst those with phobias of heart disease or tuberculosis. A special word as to asthma (spasmodic). It flourishes amongst individuals of intellectual and psychoneurotic stock; it may replace or be replaced by some other nervous manifestation; its vagaries are, for the most part, inexplicable on organic or chemical bases; attacks may be swayed by auto- or heterosuggestion in both their

appearance and disappearance; the incidence of attacks during sleep is indicative of an origin in dreams (although usually forgotten); spasm of unstriped muscle occurs nervously elsewhere; excitants of attacks may be the objects of phobias in other individuals, such as cats, horses, dogs, rats and mice, hair, feathers. Maybe, one day, protein hypersensibilities will prove susceptible to psychic explanation. Meanwhile it would be interesting to become a member (extraordinary) of the proposed asthma club, to study its mass mentality.

GENERATIVE SYSTEM.

Sexual impotence in the male, sexual frigidity in the female, spermatorrhœa, ejaculatio precox, masturbation, are of psychic origin in most cases. The same applies to vaginismus, dyspareunia, dysmenorrhœa, amenorrhœa, menorrhagia. Psychogenetic pains in the genital regions of both sexes are prone to be excruciating, or so described. Any disease or deformity of the generative organs, though it may be of practical insignificance, is liable to precipitate anxiety and depression. Pregnancy and the pains of parturition may be mimicked through hysterical mentality which can also educe phobias or pregnancy, or sterility. Local treatment for any of the nervous conditions of the genital organs is peculiarly mischievous.

CARDIO-VASCULAR SYSTEM.

In the June and July, 1927, numbers of *The Post-Graduate Medical Journal* an article of mine was published concerning nervous disorders of the heart. Vascular disorders as manifestations of nervousness may appear as blushing, pallor, "dead fingers," chilblainous extremities, angio-neurotic œdema. It is by no means as generally recognized as it should be to what extent arterial blood-pressure (especially the systolic) can be affected psychically. Yet the fact admits of easy instrumental demonstration by taking the blood-pressure of a nervous patient at

the beginning, and at the end, of a reassuring visit, when it may have fallen from 160 mm. Hg to 140 systolic, as I have observed. Conversely, anxious watching of the blood-pressure is prone to raise it in nervous subjects, hence a vicious circle. There are forms of psychoneurosis in which the blood-pressure is constantly found low. Nervously high blood-pressure should be treated with respect, e.g., I observed a young man who, in 1920, was a case of anxiety-hysteria, pure and simple, but who, on reappearing in 1926, had meanwhile developed a very high blood-pressure, systolic and diastolic, hard arteries, and hypertrophied heart, no explanation of which phenomena could be discovered other than the persistence of his nervous condition. Nervousness can prove to be an important factor in the ætiology of arteriosclerosis, organic disease though it be. There is profound pathological wisdom in the adage "it was care that killed the cat": "care" arising largely from nervous mentation.

CUTANEOUS SYSTEM.

To the unconscious mind the skin, and external appearances generally, represent fur, feathers, and colorations of the animal kingdom with their rôle of attraction to the opposite sex. Therefore skin affections, even trivial ones, may be the object upon which unconscious emotionalism may concentrate. Conversely, psychoneurosis can be the ultimate cause of erythemata that may pass on to vesiculation, sweating, local or diffuse, pruritus, and abnormal thermal sensations ranging in their descriptions from ice to fire. Some forms of alopecia, grey hair, and vitiligo are obscurely connected with nervousness.

NEURO-MUSCULAR SYSTEM.

Hysteria can originate paralysis, or paresis, of spastic or flaccid type; fatiguability; occupational cramps, contractures, tremors, twitches, tics. Reflexes may be diminished

or exaggerated, clonus may be obtained, but trophic and electrical changes in the muscles other than from disuse are rare and inconspicuous.

SENSORY SYSTEM.

Anæsthesia may be general, hemi, or local. It affects sensation of pain most usually and to the greatest degree. Localizations of hyperæsthesia or algias, may occur anywhere; along the spine, and in the "ovarian regions," they are common. When testing for sensory disturbances, it is easy for the doctor to suggest them to hysterical patients; he may find that what he has tested for and found absent, has appeared by his next examination, if he is not careful to counteract the suggestion that he expected what he sought. This rule has a general application to hysterical manifestations.

MUSCLE SENSIBILITY AND EQUILIBRIUM.

Inco-ordination, staggering, and even falling may be conspicuous. We all know the patient who gropes his way in to see us, holding on to available objects for support against falling, tells us of various falls—but may leave as a confident biped. Hysterical tumblers rarely lead to injury. Astasia-abasia is the extremity, a condition in which the patient is unable to make even an attempt at using the legs to stand or walk, yet can use them forcefully and voluntarily when recumbent.

SPECIAL SENSES.

Vision.—Anything from transient blurring or dimness to long-lasting amaurosis. Photophobia, painful accommodation. Narrowing of the visual fields, or limitations of their range of colours. Mydriasis. Strabismus, ptosis, blepharospasm. Flickering eyelids, most conspicuous with lids loosely closed. Here I am reminded of having had the privilege of examining a soldier in 1916, with the late Sir William Osler, who said that he regarded flickering eyelids, when present, as the surest objective sign of hysteria—and this diagnosis in the obscure case in question ultimately proved correct.

But nothing in medicine remains simple, with extended experience, and since 1916 flickering eyelids are to be found as a sign of encephalitis lethargica.

Hearing.—Deafness may be complete in hysteria. Or some hysterical deafness may be superadded to organic, the patient, unconsciously, no longer endeavouring to hear—it is this latter element, which is removable, that accounts for a flourishing trade in quackery for the cure of deafness. The word deafness is applied sometimes to what is really unconscious inattention—to a voice or voices that are undesirable. Intolerance to noise—that is to say noise made by other people, not their own—is a nervous commonplace. Tinnitus aurium needs a special word. It can be almost wholly hysterical, that is to say, intensify, and persist from a transient organic basis. Whatever be its basis it is prone to become the focus of extreme nervous concentration on the idea that the noise is “in the head” and will ultimately “drive me insane.” Even in organic cases the tinnitus may be rendered more tolerable by the explanation that its origin is not in the head but in the ears; in hysterical cases this often “cures,” i.e., the hysteria finds another focus for its outlet.

Taste.—This may be absent or bad, and if the latter liable to be superlatively described as “horrible,” “putrid,” “sickening,” which terms have unconscious significance.

Smell.—The same remarks apply as do to taste. Most of us must have observed how an odour can recall some forgotten circumstance. Similarly an odour, without restoring memory, may stir up, from unconscious mental depths, emotionalism in such guises as fainting, vomiting, partial or total loss of consciousness.

(To be continued).

EDITORIAL NOTES.

As interested both in hospital and post-graduate activities, we regret to have to record the death of Lord Cave, a great supporter, as is well known, of the voluntary hospital ideal; and of Dr. Chisholm Williams, a pioneer in radiology in this country, and a great sufferer in his own person for his zeal. Only last year he was awarded the “blue ribbon” of the Carnegie Hero Fund—its bronze medal “for heroic endeavour to save human life.” For several years, from 1903 onwards, he had charge of the radiological department of the West London Hospital, and was lecturer on the subject in its college.

Among the “Official Intimations” at page 148 particulars will be found of clinical demonstrations, as distinguished from lectures, which are arranged during the summer months, in the same way that fellowship lectures are arranged during the winter months. Demonstrations, we suggest, are certainly not less valuable than set lectures.

It will be seen from our “Official Intimations” columns that at Birmingham, during the earlier summer months, courses of post-graduate lectures open to all practitioners have been arranged by the University, and practical clinical demonstrations at the General Hospital and at the Queen’s Hospital.

Through the American Medical Association of Vienna arrangements have been made for the holding of a post-graduate course in neurology and allied subjects, from June 1 to July 31. This Vienna course will be given in English and all further necessary information may be obtained by writing to Dr. E. Spiegel, Falkestrasse 3, Vienna 1.

It is understood that as the result of visits to Central and Eastern Europe and the